Comments received via email re: Proposed Changes to Titles 13 & 18

(December 18, 2014 through January 6, 2015)

Jack McCullough – via email (dated 12/18/14)

Thank you, Linda. I intend to be at this meeting.

Pursuant 1 V.S.A. § § 315-320 I request copies of all documents in the possession of the Department of Mental Health, whether generated by the Department or received from outside entities, pertaining to proposed or possible changes to Title 18 or Title 13 of the Vermont statutes.

***Laura Ziegler* via email (dated 12/18/14)**

The legislative session begins January 7. And DMH will solicit input on January 6 concerning proposed statutory changes which aren't available on December 18?

No, I'm not interested in attending.

Laurie Emerson – via email (dated 12/19/14)

Hi Linda,

NAMI Vermont would be interested in receiving a copy of the proposed changes when they are available so that we can help support DMH's changes. If you could let us know when they are posted online, I can share them with our the appropriate people at NAMI Vermont.

Laurie

Representative Ann Donahue via email (dated 12/19/14)

Thank you for the notice. I will not be available on the 6th but would appreciate seeing the proposed changes.

I hope DMH will not present them to the legislature claiming they had "input" from stakeholders based on a January 6 meeting after the proposals are already drafted. I note that the December Transformation Council meeting was cancelled without explanation, and would have presented an opportunity (albeit a late one) for actual input before the proposal was prepared, functioning within its statutorily intended role. I wonder if there was discussion with the State Program Standing Committee? And as of December 18, unable to even share what the topics are beyond "Titles 13 and 18"?

"Nothing about us without us" has clearly been going down the tubes, and the irony is the Commissioner's repeated statements of the past year about the importance of working together so that there is unity against the "outside" world (such as the Legislature.) I guess "collaboration" is now expected to be a one way street.

Anne

Cathy Rickerby – via email (dated 12/21/14)

Commissioner Dupre, thanks for the invitation, but...

I will not be able to attend your meeting Tu Jan 6, a very busy day in VT, especially.

Like Anne, I'd appreciate a copy of the proposed changes re: Titles 13 and 18. ...

Thank you.

Looking forward... Cathy.

James Tomlinson – via email 12/26/14

Ms,Kemp, If you would be so kind as to get these to me by 'The Epiphany Of The Lord' ,6 January 2015 . It would be much appreciated. As I am a slow study. As it takes me time for to prepare for the public hearing of that date. Time is of the essence. Thank you in advance for your good,office's consideration. All the best, in in the New Year. To you, your kin, and all that consider you a friend. Each day is your day. Enjoy.

Heidi Henkel – via email (dated 12/31/14)

I would like information on proposed changes. I would like it sent
for me rather than to have to search for it on the website. I have a
disability that interferes with ability to search on websites. i have had multiple concussions. I tried to find it on the web site and could not- please help!

I do not know if I can get there Jan 6. I take care of an elderly man with cancer and that is a work day for me. He would have to be able to get other coverage, for me to come. That is unlikely. i can submit my thoughts in writing.

I individualized my bachelor of science degree to particularly focus on what actually works (and what actually doesn't work) in mental
health care. I was inspired to do this by my sister having

schizophrenia and seeing that much of the "care" she received from the system wasn't helpful. I helped her create a very high quality of life. However, her "medication" killed her at age 40.

From my education and from my life experience, I have a lot of honest, straightforward knowledge of what is helpful and what is not helpful.
I am not making money off of any mental health treatment and have no ulterior motivation. My only motivation is to make mental health care actually useful and nonharmful to recipients.

Heidi Henkel – via email (dated 1/1/15 - 8:35 AM)

Dear Linda,

Thanks for sending me the proposed changes to Titles 13 and 18. In case I am not able to come due to my work responsibilities, I offer some comments here.

I do not know enough about criminal justice to comment on Title 13.
However, Title 18 is within my area of work and personal experience, and academic knowledge.

Changes to Title 18; my recommendations

Specify no forced ECT.

Fraud should include misrepresenting or lying about the extent to which the patient is a danger to him or her self or to others, or misrepresenting in any way, "factual" information to back that up. What typically happens is that a provider believes a patient needs treatment, for a reason that is not supported in law, and then fabricates the "danger to self or others" part. This should be dealt with as fraud.

Housing a person who has eloped should not be considered fraud if:
there is convincing evidence that the person was being abused in the facility they eloped from, or, if the housing is preventing the person from serious illness or injury or death, or, if the person housing the eloped person contacts the police or a licensed mental health agency and informs them of the situation, or, if the person has been authorized or requested by the police or any licensed mental health agency, to do this. (I was in a situation like this, where a person eloped and was freezing to death in a snowbank according to the Springfield police. They called me and asked me to come get an house the person, because the person trusted me and no one else. I went and got and housed the person, and kept HCRS informed of the situation.
This is not fraud. These exceptions are important in making the mental health system accessible to autism spectrum patients in particular, who may not know what process to follow if they want to challenge their detainment or feel that they are being abused.)

To go along with that, it should be visibly posted in every facility that holds people involuntarily (including emergency rooms), what patients' rights are, who to contact if you want to challenge your detainment, who to contact if you feel you are being abused. This can decrease elopements by giving people accurate information about what to do in these situations.

Referral to involuntary care by nurses and physicians assistants:

This is a response to the problem of there not being enough psychiatrists. This problem should be addressed in another way, to bring more psyhiatrists to Vermont and train more psychiatrists in Vermont. Basically what is happening nationwide (this is according to a talk by a psychiatrist i attended) is psychiatry as a profession isn't attracting many medical students because it's not an appealing profession to go into, because psychiatrists don't do patients much good. UVM is in a good position to offer a cutting-edge psychiatry program that would change this. There are psychiatrists working at Fletcher Allen and at Howard Center, and across the lake in upstate NY, who could lead a program in which psychiatrists could be trained in a broad range of skills that would equip them to be much more helpful to patients than what currently goes on in psychiatry. In particular the medical director at the Howard Center and one of the child psychiatrists at Fletcher Allen.

For now: referrals should be made by a physician (MD, ND, or DO) trained in differentiating between mental health issues, adverse reactions to psychiatric drugs, and physical illnesses that cause psychiatric symptoms (which include brain tumors, some kinds of infections and nutrient deficiencies, toxicities, and so on). If there is not a physician trained in this, available, a team of providers that, between them, can do this, and that includes one physician, is acceptable. If this is not possible (strong documentation required, of having made an effort and of this not being possible) then a provider other than a physician, who has a substantial amount of this training (nurse practitioner or physicians assistant) can make this referral. If this is not possible (strong documentation required) then any physician, NP, or PA can make this referral. If this is not possible (strong documentation required), a referral by any mental health professional is acceptable. If the initial referral is made by someone other than a physician or other licensed health care provider who is trained in differentiating between mental illness, adverse reaction to psychiatric drugs, and physical illness with psychiatric symptoms, the referral must be confirmed by such a physician before it can go forward in the process.

The second exam (by a physician other than the person who made the initial referral) MUST be done by a physician trained to differentiate between a mental illness and a medical problem that causes psychiatric symptoms, even if this physician has to be brought in from out of state. In addition, this examining physican must be trained in differentiating between a temporary reaction to stress that can be mitigated with de-escalation and counseling, and a larger mental health issue that requres more long term intervention.

The reason I recommend this is because more than half of what is seen as "severe mental illness" is either adverse reaction to psychiatric drugs, or medical problems that cause psychiatric symptoms, that can be completely resolved by treating the medical problem. A word about adverse reaction to psychiatric drugs: a lot of suicidal and violent tendencies are caused by psychiatric drugs, antidepressants in particular. This needs to be differeniated at the entry point so that the patient is not further harmed by additional incorrect treatment.

[In another law or set of laws, not Title 18, we would require physicians in VT who diagnose mental illness (this is psychiatrists, pediatricians, internists, etc) to get a certain number of CMEs per year on how to differentiate between mental illness, adverse reaction to psychiatric drugs, and physical illness with psychiatric symptoms, and how to treat the latter. In addition, they would be required to

get other CMEs from programs not funded or influenced by drug companies, and continuing education in patient relations, bedside manners, counseling, or other modtalities that would improve their ability to relate to patients. By 2020, physicians working in these fields in VT would be required to have a high level of traiing in these areas. VT would have a program to help pay for this training, UVM would offer some of this training, and DMH would hold CME workshops in which providers from outside of VT are brought in to teach.]

7503; My proposed change:
If a minor under age 14 does not consent to treatment and the parent wants to consent in their behalf, this goes to a court process with a guardian ad litem involved on behalf of the child. If a minor under 14 in state custody is proposed to be given involuntary treatment, this goes through a court proess with aa guardian ad litem on behalf of the child.

7113
All patients should always have a right to a second opinion by a provider of their choice, and in addition, an evaluation by their regular outpatient health care or mental health care provider if this has not already been done.

7251
In the goals should be included to have a mental health system that is competent in a diversity of treatment options, including ones other than drugs, and to reduce the system's dependence on psychiatric drugs and involuntary psychiatric drugs to meet its own needs (safety, availability of beds, etc) in relation to treatment of patients.

Question: How often does it happen that delay of availability of appropriate and desired voluntary treatment leads to deterioration of patient, leads to involuntary care? Can we reduce this? This should be a goal also.

7620 and 7622
To argue that more time isn't going to improve doctor/patient relations, the applicant should have to prove that the doctor and others at the facility have a high degree of training or related life experiece, in being able to relate to patiets, and document what has been tried, to attempt to relate to the patient. The doctor should be required to describe the situation from the patient's point of view and explain the patient's preferences from the patient's point of view (demonstrate capacity for empathy for this patient; if the doctor is not capable of this, the doctor isn't competent to be treating the patient).

7625
The judge should evaluate the ability of both parties, to appreciate consequences of medication decisions. If the doctor misprepresents or understates the possible negative consequences of force medicating the patient, the doctor does not appreciate the consequences and the application is disqualified.

Other general concepts:

if a person is involuntarily medicated, they should be offered substantial help and support in getting off the drugs later, not just an ending of the involuntary medication order (which leads to cold-turkey discontinuation without support, which leads to a revolving door). All facilities that force-medicate should be capable of helping patients get back off the drugs, by 2020, or be de-licensed to operate in VT.

If a person is force medicated in Vermont, the state of VT and the facility doing the force medicating should jointly share the liability for any harms that come to the patient because of this involuntary medication.

Patients should never be billed for forced "treatment" that turns out to be harmful or unnecessary.

In S.287 last year, there was a provision that hospitals must provide alternatives to psychiatric drugs if the patients do not want the drugs. Where did this go? This needs to be included, and revised to give it teeth. My proposed changes: Hospitals must document their efforts to provide treatments other than psychiatric drugs, and their adequate training to do so and adequate staffing to do so, in order to be granted an order of involuntary medication. By 2020, hospitals without complete training in at least two adequate mental health modalities other than drugs, for the conditions they are treating, and at least a 1:1 staff to patient ratio at all times, would lose their VT license to treat involuntary patients.

Other related law change I propose:
All involuntary medicating of minors should go through a guardian ad litem court process. This especially includes all children in state custody, including foster care. It also includes children living with their biological or adoptive parents. Before prescribing any psychiatric medication, including an ADHD medication, sleep aid, antidepressant, or anti-anxiety medication, the child should be informed that they have a right to this process. If they are too young to understand this (under age 10), the default is to have this process. Over age 14, a child cannot be forced to take any drug of this nature, in foster care or in a home with their biological or adoptive parent.

A comment to think about: 7708 is teling, of a big part of what's going on with "non-emergency involuntary medication" in Vermont today.
We need to be much more thoughtful about this and think more about what needs it meets, and how to, long term, meet those needs in other ways so that this practice may someday go the way of 7708. It's actually not very much different; all the psychiatric drugs, and especially antipsychotics, have been documented to cause substantial brain damage and long term decline, including of the target symptoms of the drug. Stop and think about what 7708 says about the values in the mental health system at that time, and how this has and has not changed, and how, in the future, it could change more than it has.

Heidi Henkel – via email (dated 1/1/15 - 9:08 AM) "my complete and corrected version: recommendations to changes to title 18"

Hopefully, this will be taken seriously and this will be the only communication I will ever need to make to you about these matters.

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custody, including foster care. It also includes children living
with their biological or adoptive parents. Before prescribing any psychiatric medication, including an ADHD medication, sleep aid, antidepressant, or anti-anxiety medication, the child should be informed that they have a right to this process. If they are too
young to understand this (under age 10), the default is to have this process. Over age 14, a child cannot be forced to take any drug of this nature, in foster care or in a home with their biological or adoptive parent. Antipsychotics should be prescribed to minors ONLY for actual psychosis (not to treat ADHD or annoying behaviors) and only after other means of treatment have been tried and documented, and only after a court process including a guardian ad litem. This is because of the extreme nature of the harm to children caused by these drugs.

Psychiatric drugs should never be prescribed "off-label" to children or to elders with dementia in any situation (even "voluntarily;" it's not really voluntary with those populations), and should never be prescribed "off-label" involuntarily. This includes for purposes that are not FDA approved, in dosages that are not FDA approved, or in
combinations that are not FDA approved. Antipsychotics should not be
prescribed "off label" for any reason, to anyone, ever.

Voluntary prescriptions of psychiatric drugs should always be accompanied by complete information about possible harmful effects, and information about alternatives, and how to access them (and they should be accessible logistically and financially). There should be
documentation that this was done, such as something the patient signs, similarly to what is now done with privacy policies. If the patient is not able to read in English, that must be accommodated.

Doctors who violate these standards shoud have their medical licenses suspended or revoked.

(One doctor tried to prescribe an antipsychotic off-label to my friend with cancer, as an anti-nausea. Without correctly informing him of the possible side effects. Thank goodness there's medical marijuana and he has a friend who can supply accurate information about antipsychotics. It's not acceptable to prescribe a drug with such severe harmful effects or without accurately explaining these.)

A comment to think about: 7708 is teling, of a big part of what's going on with "non-emergency involuntary medication" in Vermont today.
We need to be much more thoughtful about this and think more about what needs it meets, and how to, long term, meet those needs in other ways so that this practice may someday go the way of 7708. It's actually not very much different; all the psychiatric drugs, and especially antipsychotics, have been documented to cause substantial brain damage and long term decline, including of the target symptoms of the drug. Stop and think about what 7708 says about the values in
the mental health system at that time, and how this has and has not changed, and how, in the future, it could change more than it has.

Heidi Henkel – via email (dated 1/2/15 - 6:37 PM)

Great!
I shared my ideas with some people and got some feedback and additional information about what is going on, and from that, I have some more to say, but it will take me awhile to write it. i will get back to you.

Rick Barnett – via email (dated 1/5/15)

Hello,

I look forward to seeing Paul at the Mental Health council meeting this Thursday morning.

As Legislative Chair and immediate past president of the Vermont psychological Association, I would like to comment on the definition of "licensed independent practitioner" as a proposed change in title 18, page 1. (See invitation to public forum below).

The recommended language is to include licensed psychologist-doctorate in the section "a physician, an advance practice registered nurse licensed by the Vermont Board of Nursing as a nurse practitioner ~~or~~ a Physician Assistant licensed by the Vermont Board of Medical Practice or a Psychologist-Doctorate Licensed by the Office of Professional Regulation."

The rationale for this inclusion is that the psychologist-doctorate is uniquely qualified in the health care community to assess and diagnose persons with mental illness, with significantly more education, training, and experience than most other health care professionals who assess, diagnose, and treat mental health conditions. This is a critical issue for access to and assurance of high quality health care in Vermont. This would demonstrate Vermont's (and DMH's) commitment to true integrated care. As a practical matter, the inclusion of Psychologist-Doctorate in this definition would provide better care for patients, relieve the burden on hospitals unable to fine psychiatrists, and create expanded practice opportunities for interested psychologists.

Being unable to attend the public forum tomorrow, Jan 6 9a-11am, it is requested that this email be included in consideration of the proposed changes.

Jeffrey McKee – via email (dated 1/6/15)

Good Morning Paul,

Thank you for the opportunity to review the draft changes to Title 18. I am sorry that I am also unable to attend the forum this morning. I was away from the office last week and did not have time to adjust my schedule to attend.

I want to express my strong support for inclusion of the language Rick has proposed. As he points out, Psychologist-Doctorate are uniquely qualified to assess and diagnose mental illness. As a practical matter, the inclusion of Psychologist-Doctorate in the definition could substantially reduce the burden on Hospitals in some parts of the State where psychiatrists are not on staff and/or not available.

Barb Prine – via email (dated 1/6/15)

Hi Linda,

I am a staff attorney for the Disability Law Project of Vermont Legal Aid. We represent individuals civilly committed to the custody of DAIL because f dangerous behavior.

I just got notice of the hearing today on proposed changes to Title 13/18. Could you please put us on the list of those who wish to be kept up-to-date on the proposal as it moves along?

Thanks,

Barb Prine

Sarah Knutson – via email (dated 1/6/14)

I'm attaching an alternative and/or complementary legislative agenda to that proposed by the Commissioner. It requests legislation to (1) correct broadscale systemic misrepresentation related to the effectiveness of psychoactive medications, (2) put an end to medication/ pathology-biased diagnostic practices that routinely overlook the impact of trauma and effectively 'blame the victim' for expressing distress; and (3) provide adequate non-medication supports and required systemic review whenever people are treated involuntarily on either an inpatient or outpatient basis. I wrote this from memory, so the statistics cited are correct within a few percentages Most information comes directly from Whitaker (Anatomy of an Epidemic) and also from a Trauma Magazine published by the National Association for Behavioral Healthcare in 2011. I will update with exact stats and references as time permits.

I plan to be at today's hearing. If you are able to make copies of my comments on this short notice, I would appreciate it.

Thank you for your consideration.

ATTACHMENT (see next page)

Vermont Mental Health Services

Necessary Remedial/ Corrective Legislation

1. Corrective Action/ Informed Consent re: Psychoactive Medications

The Legislature should pass the following informed consent legislation to correct the record on psychoactive medications and to ensure that Vermonters who are considering taking psychoactive medications are adequately informed of the risks:

Any practitioner who proposes to prescribe psychoactive medications for a psychiatric condition must provide the following warning / acknowledgement and obtain, in writing, informed consent from the person (and their parent/ guardian, if applicable) before prescribing such medication:

1. There is no proven genetic or biological cause of 'mental illness.'

2. Psychiatric medications do not correct any known biochemical imbalances in the brain. After several decades of research, scientist still to do not know how they actually work.

3. Currently, there are very few current drug that are not funded by Pharma and/ or conducted by Pharma-funded researchers.

4. The Pharma studies that do exist show that, at best, some people benefit from psychoactive medications. However, this is often at the cost of life-limiting, disabling or life-threatening 'side effects'.

5. The non-Pharma studies that do exist suggest the following:

- About 80% of people will be better off if they are never exposed to psychiatric medications;
- People in Third world countries where medications are not widely available have a much higher long-term recovery rate from schizophrenia and bipolar disorder (33- 66%) than people in first world countries where medications are routinely prescribed (only 8%)
- Recovery rates in the United States in 1950 (before psychiatric medications were widely prescribed) were vastly higher for bipolar disorder and schizophrenia (33-66%) than they are today (only 8% now that psychiatric medications are widely in use).
- People with serious mental health conditions who are medication compliant do worse and die sooner (25 years sooner!) that those who are non-compliant.
- Many psychoactive medications have serious (sometimes irreversible) effects that may result in reduced physical, emotional or cognitive functioning, permanent disability and even death.
- Many psychoactive medications produce short-term, immediate relief from symptoms, but this should be weighed carefully because long-term prognosis often worsens as a result.
- Those with the best recovery rates from serious mental illness are the people who are never exposed to psychiatric medications.

6. Significant evidence now suggests that Pharma and the American Psychiatric Association have been materially misrepresenting the effectiveness of psychiatric medications for their own financial/ professional gain at great cost to both individual patients and the public at large.

7. Many people have successfully recovered from severe psychiatric conditions without the use of psychiatric conditions.

8. Many people believe that stopping the use of psychiatric medications either enhanced or enabled their recovery.

Sarah Knutson, MS/ JD **sarah@peerlyhumanfamily.org**

2. Corrective Action/ Informed Consent re: Psychiatric Diagnosis

Part A: Informed Consent.

The Legislature should pass the following informed consent legislation to correct the record on psychiatric diagnosis. This is necessary to ensure that Vermonters seeking mental health services are accurately informed about, and screened for, the impact of trauma on their biopsychosocial well-being.

1. There currently is no accurate means of diagnosing a mental health disorder or distinguishing one so-called 'disorder' from another. After decades of research, so-called experts still cannot agree.

2. There is no known biological or genetic cause to 'mental illness.' To the contrary, recent advances in genetic mapping suggest that the neurological factors involved in 'mental illness' are even broader and more diverse than the factors involved in determining human intelligence.

3. By far, the most common correlate of mental health system involvement is trauma. Approximately 90% of those in the public mental health system, substance use treatment or corrections settings - and more than of 90% of homeless individuals – are survivors of childhood trauma. Many others may be experiencing the after-effects of a material, emotional, physical, economic, relational or existential traumatic stressor that occurred later in life.

4. Many of the symptoms of traumatic distress, including chronic adaptations to traumatic distress, are identical to those of serious mental conditions, including psychosis, dissociation, mood irregularities, motor/ speech/thought disturbances and suicidal/ homicidal ideation.

5. If you have not been screened for the after-effects of distressing or traumatic life experiences, events or circumstances, your service provider should do that now.

6. If you are suffering from the effects of traumatic distress (past or present):

- Your symptoms may greatly reduce when the source of your distress is addressed and/ or your sense of safety is restored.
- Your treatment provider should not diagnose you with a 'mental illness' or prescribe treatment for a 'mental illness' unless:
    - 1. the source of your distress has been substantially addressed; *and*
    - 2. your symptoms have not improved or remitted.
- Psychoactive medications may provide temporary relief from symptoms while you are working to alleviate the source of your distress. However, you should weigh the risks carefully because the long-term costs may be significant and irreversible.
- Safe and effective alternatives to psychiatric medications exist. They include trauma-informed care, Hearing Voices, Open Dialogue, person-centered therapy, motivational interviewing, family therapy, cognitive behavioral therapy, art or movement therapy, narrative therapy, Wellness Recovery Action Planning, peer respite retreats, peer wellness centers and Intentional Peer Support.

Part B. Corrective Action:

The Vermont legislature should mandate the following corrective actions in order to insure that actual sources of traumatic distress for Vermonters are properly acknowledged and addressed by mental health professionals. This is necessary to counter the widespread misuse of medication-only

approaches that continue to 'blame the victim' and pathologize Vermonters' legitimate responses to distressing life circumstances and events. At a minimum, this legislation should provide for:

1. Proper Screening: Whenever any person presents or is presented for a mental health assessment, the following is required:

- ACES Screening upon admission
- Comprehensive screening for current, ongoing, or previously unaddressed biopsychosocial stressors.

2. Proper Treatment: Where ACES or biopsychosocial factors are identified:

- The admission reason for the current treatment episode shall be provisionally listed as such factor(s).
- Such factor(s) shall be accepted for insurance purposes as the provisional diagnosis.
- Unless and until the identified factor(s) are substantially resolved or addressed, the Initial treatment plan shall focus on:
    - Such factor(s), and
    - supporting the person to alleviate or cope with symptoms/ distress
- The reasonable costs involved in alleviating the persons traumatic distress shall be considered legitimate medical expenses and reimbursed as such by insurance, without regard to whether such costs include 'traditional medical services.'

3. Proper Diagnosis: No person shall be diagnosed with a 'mental illness' unless and until:

- The assessments Part A.1. have been diligently conducted in good faith, properly documented in the record, reviewed with the service recipient and acknowledged in writing by both parties.
- The person has been offered a broad selection of trauma-informed interventions, including any intervention (whether medication or non-medication) that the recipient requests and could be made reasonably available with due diligence on the part of the provider or the Designated Agency in the locality where service recipient resides
- All identified potential sources of traumatic distress have been substantially addressed; and
- The person's symptoms have failed to remit or materially improve.

3. Corrective action re: systemic re-traumatization

Systemic re-traumatization is a common and serious problem in emergency rooms, healthcare settings and when emergency responders are called in to assist in containing an emerging situation. The trauma cuts all ways and affects everyone on all levels, including emergency responders, service providers and service recipients. Sadly, much of this trauma is needless and avoidable. In fact, some psychiatric inpatient settings have reduced their use of involuntary interventions, including seclusion and restraint by over 99% after making a concerted effort at training, prevention, and non-violent implementation over a period of years. Accordingly, to protect Vermonters in mental health care situations from avoidable re/traumatization, the Legislature should require the following:

1. All staff whose job roles include interacting with service recipients must be trained in trauma-informed care and eCPR. Training must including annual refreshers for both modalities.

2. All service recipients who are receiving involuntary care (or who could be reasonably foreseen to be at risk for receiving involuntary care) – where at the inpatient or outpatient level, must have:

A. 24 hour access to someone (whether staff or volunteer) who is:

- Trained in trauma informed care, Intentional Peer Support and communicating across alternate realities.
- Trained in supporting and facilitating communication for both people in distress and for people who experience communication deficits.
- Available within 15 minutes of a request to listen/ assist in person for at least 2 hours per day
- Available for the remaining 22 hours by phone, text, internet, or in person.

Such services are deemed necessary upon request and are billable to insurance at reasonable healthcare rates.

B. Daily access to non-medication trauma-informed group learning experiences (whether offered by staff or volunteers), including:

- A minimum of one of the following per day and four different modalities per week:
    - Intentional Peer Support
    - Hearing Voices Network
    - Wellness Recovery Action Planning
    - Icarus Project Groups/ Activities
    - Harm Reduction for Coming off Psychiatric Mediations
    - NAMI Peer-to-Peer
    - Family Therapy
    - DBT
    - CBT
- Art/ Creativity
- Movement / Fitness
- Stress-Reduction training (Yoga, Mindfulness, Meditation, etc)

3. Every instance of involuntary care or treatment will be considered as a system failure and a potential trauma risk for both staff and service recipients - whether involved as participants or vicariously affected as witnesses. In order to prevent further/ future personal distress or systemic re/traumatization, such persons must be offered access to:

- A safe, confidential, free avenue to process and make sense of their experience (within 1 hour).
- Independent advocates (within 24 hours) to assist them to communicate their concerns and make recommendations for systemic changes, including the following:
    - coaching and in person communication assistance as requested to restore any relationships affected, whether in the healthcare setting or otherwise.
    - an in-person incident debrief meeting with agency management within 1 week
    - an in-person opportunity for facilitated resolution with others involved within 2 weeks

Agencies are required to fully collaborate with these procedures and implement all reasonable remedial recommendations in good faith or face treble damages.